

# 2010 Primary Care Associates an affiliate of US HealthWorks

## PATIENT INFORMATION *Please Print*

Date: \_\_\_\_\_

**Patient Information:**  Adult  Child

First Name: \_\_\_\_\_ MI. \_\_\_\_\_ Last Name: \_\_\_\_\_ Birth date: \_\_\_\_\_

Male  Female  Married  Single  Other

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_

Social Security number: \_\_\_\_\_ --- --- Drivers License number \_\_\_\_\_

**Person Responsible for Account:**  Self  Other \_\_\_\_\_ Birthdate: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_

Social Security number: \_\_\_\_\_ --- --- Drivers License number \_\_\_\_\_

(Circle one)

**Spouse/Parent/Guardian Name:** \_\_\_\_\_ Social Security: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_

### Information below cannot be obtained by photocopy

#### Primary Insurance:

#### Secondary Insurance:

Person Policy Issued to: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

Group Number: \_\_\_\_\_

Policy or ID #: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

***This information is necessary for our courtesy billing to your insurance company. We can NEVER guarantee payment by your insurance company. The insurance company's contract is with you and your employer.***

In case of emergency notify: \_\_\_\_\_

Phone: \_\_\_\_\_

Nearest relative or friend not living with you: \_\_\_\_\_

Phone: \_\_\_\_\_

Signature: Patient / Guardian : \_\_\_\_\_

Date: \_\_\_\_\_

Any Subsequent Insurance Changes must be Provided Prior to Any Office Visit ~Or~ Lab Testing. Thank You!